DIVISION OF WORKERS' COMPENSATION

APPLICATION FOR PAYMENT OF ADDITIONAL REIMBURSEMENTS OF MEDICAL FEES

W.C. Injury Number
Medical Fee Dispute Number

Use only if partial payment has been made and the amount of the fee billed is in dispute.
See instructions on reverse side..

Employee (Patient's) Name	Address (Street, City & County)	State	Zip Code	Date of Injury
				Patient's Social Security Number

1. Application is made for additional payment of health care services rendered to the employee above the amount already paid in the underlying workers' compensation case. The medical or health care bill is being disputed by the employer/insurer. (NOTE: The employee is not a party to the medical fee dispute and should not be made a part of or otherwise notified of such proceedings.)

2. Name of Health Care Provider	Address (Street, City & County)	State	Zip Code	Telephone Number
2 a. Location of services rendered (If different than above.)	Address (Street, City & County)	State	Zip Code	Telephone Number
3. Name of Employer	Address (Street, City & County)	State	Zip Code	Telephone Number
4. Name of Insurer	Address (Street, City & County)	State	Zip Code	Telephone Number

5.	Brief Description of Disputed Services Rendered	Date Services Provided	Amount Billed	Amount Paid	Amount Claimed
A.			$	$	$
B.			$	$	$
C.			$	$	$
D.			$	$	$
E.			$	$	$

(If additional space is required, please attach additional page.)

6. Explanation of Reasonableness for each disputed service: (Please attach additional page and supporting documentation.)

7. Signature of Applicant	Name/Title/Address of Applicant (Print/type)	Date
		Telephone Number
8. Applicant's Attorney & Address (Print/type)	Attorney's Signature	Date
	Bar Number:	Telephone Number

CERTIFICATE OF SERVICE:

The undersigned applicant certifies that the foregoing information is true and correct to the best of his/her knowledge, information and belief. The undersigned applicant further certifies that she/he has discussed this dispute with an authorized representative of the employer/insurer and has attempted to resolve this dispute.

Applicant or Applicant's Attorney

INSTRUCTIONS

This form (WC-MD-02) is to be used in medical fee disputes involving the "Reasonableness of the Amount of Fee Charged." Be sure you understand the different types of medical fee disputes, and choose the applicable procedure and form to avoid delay or confusion in the handling of your file. (See, "Medical Care/Fee Disputes" general information material.)

A dispute involving the "Reasonableness of the Amount of Fee Charged" is between the employer/insurer and the health care provider as to whether the fee charged by the health care provider is fair and reasonable.

In these instances, the employer/insurer recognizes that the underlying workers' compensation claim is compensable, and has authorized the health care provider to provide treatment to the injured employee. The issue in dispute is limited to the amount of the fee charged by the health care provider. The employee is not a party to this dispute, and his/her right to workers' compensation benefits may not be jeopardized by such dispute.

The administrative procedures involved in this dispute are as follows:

STEP ONE: The health care provider is notified by the employer/insurer that the amount of the medical fee charged is in dispute. The health care provider and employer/insurer make an earnest attempt to resolve the dispute.

STEP TWO: If the parties are unable to resolve their dispute as to the reasonableness of the medical fee charged by the health care provider, the health care provider files with the Division of Workers' Compensation in Jefferson City, Missouri (3315 West Truman Boulevard, P.O. Box 58, Jefferson City, Missouri 65102) an original and two copies of an Application for Payment of Additional Reimbursements of Medical Fees.

STEP THREE: The Division of Workers' Compensation creates and assigns a medical fee dispute number to a file, and returns to the health care provider the two file stamped copies.

STEP FOUR: The health care provider shall serve through personal service or by certified mail, return receipt requested, a file stamped copy of the application upon the person or corporation against whom the application has been filed.

STEP FIVE: The parties are encouraged to resolve their dispute without the assistance of the Division of Workers' Compensation. If unsuccessful, either party may request or the division may schedule a mediation conference.

STEP SIX: If the parties have attempted in good faith to resolve their dispute, but have been unsuccessful, either party may request or the division may schedule a pre-hearing conference. The employer/insurer must file with the division an Answer to the Application For Payment of Additional Reimbursements of Medical Fees within thirty (30) days of the date of the Notice of Pre-hearing Conference.

STEP SEVEN: If the parties are unable to resolve the dispute by agreement, either party may request an evidentiary hearing, which will be subsequently scheduled and a decision will be issued. Alternatively, both parties may request an administrative ruling. The parties have the right of appeal to the Labor & Industrial Relations Commission, See, 8 CSR 50-2.030(17).